

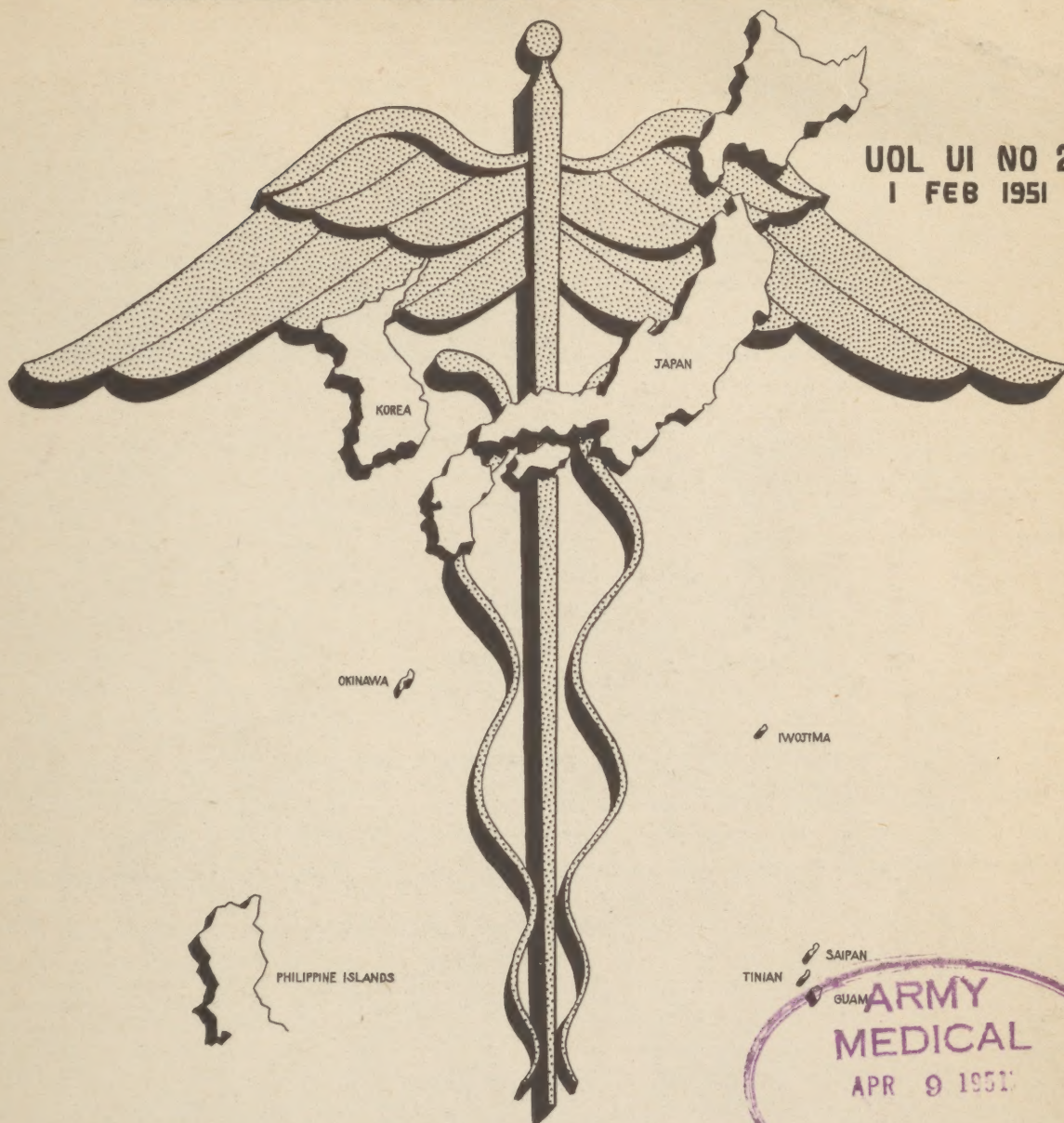
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SURGEON'S CIRCULAR LETTER

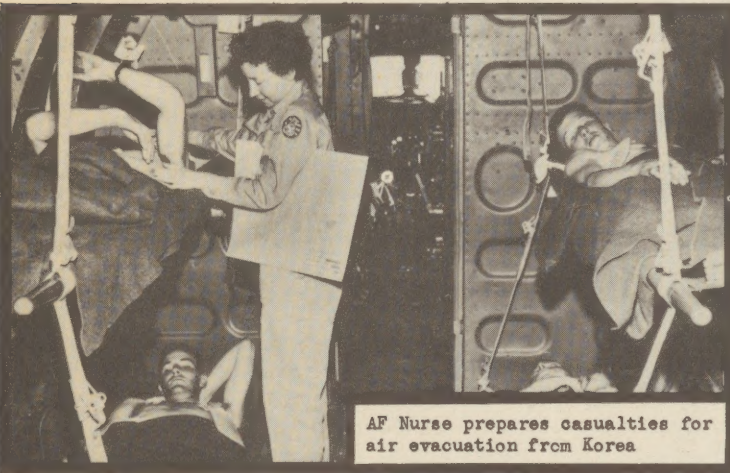
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Army Nurse feeds soldier liquid food through nasal tube, Evac Hosp, Korea



Maj Gen Edgar Erskine Hume congratulates Lt Col A. M. Gritsavage upon her award of Legion of Merit medal



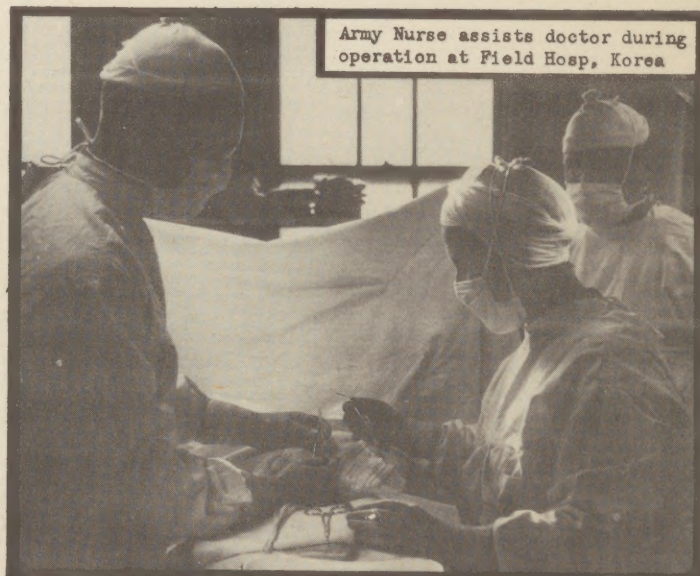
AF Nurse prepares casualties for air evacuation from Korea



Navy Nurses and wounded men leave Pusan on hospital ship



Army Nurse bandaging wounded soldier's leg at Sta Hosp, Japan



Army Nurse assists doctor during operation at Field Hosp, Korea

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NO. 2

1 February 1951

PART IADMINISTRATIVE

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I. ANC Celebrates Fiftieth Anniversary

On 2 February 1951, the Army Nurse Corps celebrated its Golden Anniversary. Just fifty years ago an act of Congress created the Corps as a recognized organization. Before that time, American women had served with distinction as nurses in all our wars, but their lack of permanent status made it difficult for the Army to maintain a nursing service of consistently high order. The establishment of the Army Nurse Corps and its integration into the military was the solution. In two world wars no better nursing care could have been given than our troops have received.

Nurses in the Far East Command found the anniversary day especially meaningful, for again they are serving under the stress of war times. With the onset of the Korean conflict, they responded with the spirit that characterizes their Corps. Throughout the first eight months of the war, the highest level of service has been achieved and maintained.

Expressions of congratulation and thanks have been forwarded from all levels of command.

General MacArthur made the following advance statement:

"When 2 February 1951 comes, the Army Nurse Corps as an organization will attain its 50th birthday. It is an anniversary of which the military service is proud, for it marks a half century of noble devotion to duty. I have seen the work of our nurses in every war since the Nurse Corps was established by Congress, so that I know at firsthand of the good that they have done.

"In the conflict in Korea the medical service has rendered magnificent care, both in keeping our men fit to fight and in treating our casualties. Never before have we held the death rate at so low a figure. Wounded men admitted to our hospitals in Korea are treated with such scientific skill, and nursed with such knowing care, that despite the effects of the enemy's most deadly weapons, our wounded's chances of recovery, and usually of return to duty, are extremely good. The thousands who have been evacuated to Japan have had the best of care enroute and in Japan have received outstanding treatment. Always our nurses do their part splendidly. When, to give but one example, our hospital that has served longest in Korea has admitted almost 30,000 patients of whom less than 70 have died, we know that long hours of work, great skill, and unflinching devotion to duty have characterized the medical work in which the nurses' role has been a major one.

"On their Golden Anniversary, I congratulate and thank the members of the Army Nurse Corps in Korea, in Japan, and elsewhere in the Far East Command for what they have done and

are still doing in assuring our fighting men the best possible medical care."

Major General Edgar Erskine Hume, Chief Surgeon, FEC, expressed his appreciation in a statement, which is reproduced in part:

"February 2, 1951, marks the 50th anniversary of the Act of Congress which created the Army Nurse Corps. It is an important milestone in the development of the medical profession in general and nursing in particular.....

"In the Korean conflict the Army Nurse Corps has been magnificent, giving so much and asking so little. No wounded man in our hospitals has lacked the gentle efficient and constant care afforded by these nurses. Those serving in Japan and elsewhere in the Far East Command have ably supported the cause by nursing patients who have been evacuated from Korea.

"On the Golden Anniversary of the Army Nurse Corps, which is likewise the Golden Anniversary of its sister the Air Force Nurse Corps, I congratulate the nurses and express to them the thanks of a grateful country. Associated with them are nurses of the Navy and of the United Nations. They too have ably done their duty. I extend to all the nurses of the command my thanks for their good work."

Army nurses in Korea took time out on 2 February to celebrate the day. Two airplanes loaded with delicacies for anniversary dinners in various hospitals were dispatched from Tokyo on 31 January.

Lt Colonel Alice M. Gritsavage, Chief Nurse, UN and FEC, who originated the party food flight to Korea, accompanied one plane load to Pusan and attended the anniversary banquet there. Lt Colonel Elizabeth C. Mahoney, Chief Nurse, Japan Logistical Command, was on the second plane and attended the festivities in Taegu.

Colonel Gritsavage had particular cause for celebration. A few days earlier she had been awarded the Legion of Merit Medal, the first nurse so honored since the beginning of the Korean campaign. The presentation was made in a brief ceremony on 30 January in General Hume's office and was attended by all the Chief Army Nurses in the Tokyo-Yokohama area.

II. Danish Hospital Ship Adds to UN Medical Facilities

The hospital ship "Jutlandia" is scheduled to arrive in Korean waters early in March as Denmark's contribution to the UN effort.

The former transatlantic liner sailed from Copenhagen during January after being re-fitted for her new task. With a gross tonnage of 8,500, she was one of the finest vessels in the Danish commercial service. Equipping her as a hospital ship cost the Danish government approximately \$1,000,000.

The cargo holds have been turned into hospital wards with a total capacity of 200 patients. With additional emergency berths, the ship can accommodate 400 patients. Three main clinics, two operating theaters, a dental clinic, X-ray laboratory, dispensaries, library, and other facilities have been provided. The total medical and nursing staff is 100. Several of Denmark's leading specialists are among them.

Before leaving Copenhagen, the Jutlandia took on large supplies of medicines, vaccines, serum and instruments. It will carry 1900 tons of fresh water, and special apparatus will enable the ship to convert sea water into distilled water.

III. Procedure for Complaints Concerning Unsatisfactory Ordnance Materiel

Complaints concerning unsatisfactory Ordnance Materiel have been noted in Annual Reports of Army Medical Service Activities submitted by units of Eighth Army. These complaints have been brought to the attention of the Ordnance Section, GHQ, FEC. The following suggestion submitted by that office is published herein as a matter of information for personnel concerned:

"On future complaints concerning unsatisfactory Ordnance Materiel, it is requested that the using Medical organization be instructed to prepare an Unsatisfactory Equipment Report (DA AGO Form 468) as prescribed in SR 700-45-5, 19 Sep 49. This will expedite the handling of complaints and assist this office in insuring that better equipment is furnished to the Medical Corps."

IV. Awards to Army Medical Service Personnel

The following additional Army Medical Service personnel have been awarded the Air Medal, Silver and Bronze Star Medals for exceptional bravery in face of the enemy and meritorious service in the Korean situation.



Adams, Raymond E., Capt, MC, BSM
 Archie, Harry R., Sgt, BSM "V" Device
 Aspinwall, Phillip, PFC, BSM "V" Device
 Austin, Albert S., M/Sgt, BSM, "V" Device
 Ayala, Jose M., Sgt, BSM
 Bailey, Don V., Pfc, DSC
 Bailey, William J., 1st Lt, MC, BSM, "V" Device
 Baker, Bradley B., Cpl, BSM, "V" Device
 Balcom, Harley L., Sgt, BSM, "V" Device
 Barker, William O., Sgt, DSC
 Barth, Tucker A., Capt, MC, BSM, "V" Device
 Beam, Richard M., Cpl, SS
 Beaton, Paul F., Cpl, BSM, "V" Device
 Beaubien, Hubert, Sgt, BSM, "V" Device
 Beerstler, John H., Cpl, BSM
 Beginski, Albert J., Pfc, BSM, "V" Device
 Bell, Benjamin H., Cpl, BSM, "V" Device, SS
 Bezemer, Paul D., Cpl, SS
 Biggs, Lawrence W., Capt, MC, BSM
 Biasaccia, Leonard J., Maj, MC, BSM, "V" Device
 Bishop, James N., Cpl, BSM
 Bitner, Leland M., Capt, MC, BSM
 Blackson, William, Sgt, BSM
 Blake, Frank L., Pfc, SS
 Blake, Margaret G., Capt, ANC, BSM
 Blankenship, Gwinitra, Pfc, BSM, "V" Device
 Bock, Harold A., Sgt, BSM, "V" Device
 Bolen, Jack, Cpl, DSC
 Booher, David D., Capt, MC, BSM
 Bowler, Ray A., M/Sgt, BSM, "V" Device
 Bralley, Ernest M., Maj, MC, BSM, "V" Device
 Brill, Andrew J., Pfc, SS
 Burke, Ezra P., Sgt, BSM
 Burnett, Thomas K., 1st Lt, MC, SS
 Burrow, Earl L., Sgt, BSM
 Bushre, Donald E., Pfc, BSM, "V" Device
 Cagle, Joseph J., Sgt, BSM, "V" Device
 Canada, Charles C., Col, MC, AM, SS
 Carlson, Paul A., Capt, MC, SS
 Carmichael, Turner, Sgt, BSM, "V" Device
 Carnica, Peter S., Cpl, BSM, "V" Device
 Cavanah, Decolia, Cpl, BSM, "V" Device
 Cear, Donald A., Pfc, BSM, "V" Device
 Chisholm, Joseph N., Pfc, BSM
 Clark, Jesse, Sgt, SS
 Coignet, Alfred J., 1st Lt, MC, BSM
 Coin, Charles M., 1st Lt, MS, BSM, "V" Device
 Collier, James R., Capt, MC, BSM, "V" Device
 Collingsworth, E., Sgt, BSM, "V" Device
 Collins, Warren J., Capt, MC, SS
 Craig, John P., Capt, MS, BSM
 Crayton, James H., Pfc, BSM, "V" Device
 Crews, Marshall L., Cpl, BSM, "V" Device
 Cunningham, Earl C., 1st Lt, MS, BSM
 Cutler, William C., Sgt, SS
 DeJesus, Gilbert, Cpl, SS
 Ditsler, Wayne H., Cpl, BSM, "V" Device
 Dixon, Bryan, 1st Lt, MC, BSM, "V" Device
 Donath, Robert, Sgt, SS
 Dorrien, Neil, Sgt, BSM, "V" Device
 Duerk, Donald L., Capt, MC, BSM
 Dunrebin, Donald W., Cpl, BSM, "V" Device
 Dusek, Ronald R., Pfc, DSC
 Eaves, Robert F., Jr., Maj, MC, BSM
 Eddy, Howard J., Capt, MC, BSM, "V" Device
 Everett, Ralph R., Sgt, CR
 Ewing, James H., Sgt, SS
 Farnsworth, Darrell, Pfc, BSM, "V" Device
 Fick, Albert E., 1st Lt, MC, BSM
 Fisher, Charles W., Cpl, BSM, "V" Device
 Fishul, Conrad G., Sgt, SS
 Flaggo, Albert J., Capt, MC, BSM, "V" Device
 Fleischmann, Richard, Pfc, SS
 Fletcher, Archibald, Maj, DE, BSM
 Flynn, Freeman J., Lt Col, MS, BSM
 Folan, John J., Cpl, BSM, "V" Device
 Frerichs, Alfred H., Sgt, BSM, "V" Device
 Fryer, Robert F., Cpl, BSM, "V" Device
 Fuller, Alvin C., Sgt, BSM
 Gamboa, Oscar, Pfc, BSM, "V" Device
 Jaton, Adam, Sgt, BSM, "V" Device
 Girard, Adlore L., Cpl, SS
 Gooden, Willie C., Pfc, SS
 Goodwin, Martin, H., Pvt, SS
 Gorby, Alvin L., Col, IM
 Gordon, James O., Pfc, BSM, "V" Device
 Gorgill, Harold R., Cpl, BSM, "V" Device
 Gould, John A., Cpl, BSM, "V" Device
 Granrath, Clarence, 2nd Lt, MS, SS
 Graveline, Ernest L., Capt, MC, BSM, "V" Device
 Griffith, Robert F., Sgt, BSM, "V" Device
 Groschuppe, Robert, Pfc, BSM, "V" Device
 Gunter, Blake K., Cpl, BSM, "V" Device
 Hall, Paul M., M/Sgt, SM
 Hardin, Kermit M., Cpl, BSM, "V" Device
 Harkins, Frederick, 1st Lt, BSM, "V" Device
 Harris, John F., Maj, MC, CR
 Hartman, Sidney, Capt, MS, BSM
 Heath, William, Sgt, SS
 Hedgpath, Leslie E., Capt, MC, BSM, "V" Device
 Higa, Susumu, Sgt, BSM
 Hinojosa, Mario C., Cpl, BSM
 Hinrichs, Herbert, 1st Lt, MC, BSM
 Hite, Harold B., Pvt, BSM, "V" Device
 Hoffman, John L., Sgt 1/c, BSM, "V" Device
 Hollister, Edwin R., Pfc, BSM, "V" Device
 Hood, Charles L., Pfc, BSM, "V" Device
 Howard, Thomas J., Capt, MC, BSM, "V" Device
 Huff, David K., Cpl, BSM, "V" Device
 Hughes, John F., Capt, MC, BSM, "V" Device
 Humphrey, Carl S., Sgt, BSM
 Jackson, Clarence, Cpl, BSM, "V" Device
 Jackson, Levi, Jr., Cpl, DSC
 Jackson, Wendell T., Maj, DE, BSM
 Johnson, Jim S., Cpl, SS
 Johnson, Jose, Pfc, BSM, "V" Device
 Johnston, Paul E., Pvt, BSM, "V" Device
 Jones, Lave J., Sgt, BSM, "V" Device
 Judd, Clark A., Pfc, BSM, "V" Device
 Kealey, Robert C., 1st Lt, MC, BSM, "V" Device
 Keith, Wilbur E., Pfc, SS
 Kelly, Richard L., Sgt 1/c, BSM, "V" Device
 Kerklm, James H., Cpl, BSM, "V" Device
 King, Charles D., 1st Lt, MS, BSM, "V" Device
 Kinson, Joe A., Pfc, BSM, "V" Device
 Kohn, Norbert O., Sgt, BSM
 Kovachik, Michael, Sgt, BSM, "V" Device
 Kuhn, Edward R., Sgt, BSM, "V" Device
 Landen, Walter J., Cpl, SS
 Lawrence, Charles, Cpl, BSM, "V" Device
 Lehman, Clarence C., Pfc, BSM, "V" Device
 Lochte, William P., Capt, MS, BSM
 Long, Warren G., Cpl, BSM, "V" Device
 Longcor, Elmer R., Cpl, BSM, "V" Device
 Lyell, Billy J., M/Sgt, BSM
 Lynch, Leo J., 1st Lt, MC, BSM, "V" Device
 MacCurdy, Dwight N., 1st Lt, DE, BSM
 Mandaglio, Mike, Cpl, BSM, "V" Device
 Mason, Joseph E., Pfc, BSM, "V" Device
 May, Carl J., Capt, MS, BSM
 McBroom, John A., Sgt, BSM, "V" Device
 McCabe, Lester, Cpl, BSM, "V" Device
 McConnell, Viola, Capt, ANC, BSM
 McCormick, Phillip, Cpl, BSM, "V" Device
 McGinty, James K., Sgt, BSM
 McIntosh, Memford, Sgt, BSM, "V" Device
 McIntyre, Gary, Pfc, LSM, "V" Device
 McKenna, Bernard, Pvt, SS
 McKinley, Andrew J., Sgt, BSM, "V" Device
 McKinney, Edward, Sgt, BSM, "V" Device
 McNabb, Willard G., BSM, "V" Device
 Meadows, Benjamin J., Maj, MC, BSM
 Mejia, Gilberto, Cpl, BSM, "V" Device
 Miller, Robert A., Cpl, BSM
 Miller, Walter P., 1st Lt, MS, BSM
 Mills, Kenneth D., Sgt, BSM, "V" Device
 Mims, James R., Cpl, SS
 Misheck, James E., Sgt, SS
 Mislosky, James J., Cpl, BSM
 Molgard, Hans G., Sgt, BSM, "V" Device
 Mollohan, Cecil S., Col, MC, IM
 Mondie, Lorenzo, Cpl, BSM, "V" Device
 Montoya, Victor L., Pvt, BSM, "V" Device
 Moore, Leopold, Cpl, BSM
 Morris, Sidney C., M/Sgt, CR
 Moulaison, Walter Jr., Pvt, BSM, "V" Device
 Mullen, Terry, Cpl, SS
 Munaf, Samuel, Pvt, BSM, "V" Device
 Myles, Jessie, Sgt, BSM, "V" Device
 Myszk, Donald L., Cpl, BSM, "V" Device
 Navarre, Vincent J., Capt, MC, BSM
 Nestor, David L., Pfc, BSM, "V" Device
 Neuman, Frank A., Maj, MS, IM
 Nopwaskey, John F., Cpl, BSM, "V" Device
 Norris, Lynn W., Capt, MS, BSM, "V" Device
 Nunley, William C., Cpl, SS
 O'Neill, Robert F., Sgt, BSM, "V" Device
 Overholt, Edwin L., Capt, MC, SS
 Pace, Vincent S., Pvt, BSM, "V" Device
 Pacheco, Samuel C., Sgt, BSM, "V" Device
 Pace, Thomas N., Col, MC, AM
 Parker, Clifford A., Sgt, BSM, "V" Device
 Patton, Michael F., Capt, MC, BSM, "V" Device
 Paxton, Alvin A., Pfc, BSM, "V" Device
 Perry, Samuel G., Maj, MC, BSM, "V" Device
 Phelps, Junior L., Cpl, BSM
 Pierce, J. A., 1st Lt, MC, BSM, "V" Device
 Pierson, W. E., Cpl, BSM, "V" Device
 Pigford, Jack D., Capt, DE, BSM
 Pofahl, Paul R., Pfc, BSM, "V" Device
 Posey, T. A., Pvt, BSM, "V" Device
 Pressey, John E., Pfc, BSM, "V" Device
 Ramos, Ralph, Cpl, SS
 Reed, John A., Cpl, BSM, "V" Device
 Reek, Robert S., Pfc, BSM, "V" Device
 Reiter, A. W. Jr., Capt, MC, BSM, "V" Device
 Rentz, Billy C., Pfc, BSM, "V" Device
 Reynolds, M. Sgt, BSM, "V" Device
 Riffe, Charlie T., Sgt 1/c, BSM
 Rivenbark, R.V., Maj, MS, BSM
 Roberts, James T., Cpl, SS
 Rogers, Kenneth, Pfc, BSM, "V" Device
 Romanski, R.A., Capt, MS, BSM, "V" Device
 Rosecrants, G., Sgt, BSM, "V" Device
 Rourke, J. C., Capt, MC, BSM, "V" Device
 Ruark, Joseph E., Sgt 1/c, BSM, "V" Device
 Schlitz, Alvin J., Sgt, BSM
 Scoles, P. S. Capt, MC, SS
 Scott, Abraham, Sgt, BSM, "V" Device
 Sears, Carl D., Cpl, SS
 Seidl, James G., Cpl, SS
 Sharkey, Charles A., Pfc, BSM, "V" Device
 Sharp, John H., Capt, MC, BSM
 Sherrer, John H., Sgt, BSM, "V" Device
 Sherron, Howard, Sgt, SS
 Shifflett, O., Cpl, BSM, "V" Device
 Shifflett, J. F., Pvt, BSM, "V" Device
 Shurr, Charles F., Pfc, BSM, "V" Device
 Sill, Dale F., Pfc, BSM, "V" Device
 Silvertson, Sigurd, Capt, MS, BSM
 Simmons, Howard W., Cpl, BSM, "V" Device
 Simmons, Joseph W., Sgt, SS
 Smith, Arthur L., Pfc, BSM, "V" Device
 Smith, Donald L., Pfc, BSM, "V" Device
 Smith, James C., Sgt, BSM, "V" Device
 Smith, Ray C., Cpl, BSM, "V" Device
 Snell, Maynard J., Capt, MS, SS
 Snow, James C., Sgt 1/c, BSM, "V" Device
 Soards, Henry L., Pfc, BSM, "V" Device
 Sosabee, John H., Pfc, SS
 Staats, Raymond A., Cpl, SS
 Stinson, Bobby R., Cpl, BSM, "V" Device
 Swardi, Thomas, Cpl, BSM, "V" Device

(Additional listings will be published in the 1 March 1951 issue of The Surgeon's Circular Letter.)

V. Nursing Care of Korean POWs - Lt. Marie T. Genest, ANC

We were in Taegu when our original enemies, the North Koreans, were being battered back to beyond the 38th parallel. The month was September and the weather was that humid, oppressive, penetrating heat that one was unable to avoid until the searing sun withdrew behind the rugged mountains. With the exception of a few UN casualties, the primary duties of the 171st Evacuation Hospital was treating prisoners of war. The Army nurses and doctors were not only confronted by superstition, fear, and a tremendous language barrier, but also with very minimal time in which to practice good medicine and nursing care. These patients remained with us no longer, usually, than 24 hours or less, the exceptions being serious and critical cases.

When we first received POW contingents, they were obviously racked with fear - of us! When we picked up some of their stretcher cases for surgery, high piercing screams, babbling and the fast speaking mumbo-jumbo of the Korean language blasted our ears like bombs bursting on targets. Others would gaze at us from panic-ridden eyes - saying nothing, but rigid with dread. Of what? That's where we were stumped and completely baffled. Here was an American Hospital, prepared to give the same medical care to these little killers that we were giving our own men. We were using the same plasma, blood, penicillin, medical and nursing skills for which the American Armed Forces are considered so outstanding - and yet, these POWs were howling objections upon objections! There must be a good reason for all of this furor.

In an attempt to get at the bottom of the uproar, a French missionary priest was asked to come and talk to the prisoners. Upon interrogation, he discovered that these North Koreans had been instructed that the Americans were vicious, sadistic people, who would amputate their arms and legs just for practice. The priest attempted to reassure the POWs, but he might as well have attempted to convince Old Joe himself. They were not assured - they were hysterical! The hospital staff had a hurried conference and it was decided that a little old fashioned common sense might be most effective. Before the plan can be related, however, it is necessary to give the reader a verbal picture of our medical compound in Taegu.

We were housed in a teacher's college; there were four long wooden, grey buildings connected by ramps. The architecture was typically oriental, in that it possessed sliding doors throughout the buildings and a tremendous number of windows which were noted for their varied sizes. To the side of the wooden structures was an immense inclosed yard where we pitched eight large tents. One of these tents was used for surgery (it contained four active tables), one for the medical cases, two tents as admitting sections and the other four were divided as pre- and post-operative sections.

The school itself sheltered the UN patients. We kept our supplies in the school auditorium, converted class rooms into a surgery, central supply, medical and surgical wards, sleeping quarters for the personnel and more POW sections. It was a good, well-organized set up.

Getting back to the treatment of the POW patients....to alleviate this serious, emotional stress of the propaganda ridden POWs, our plan was to return the post-operative cases to their original tents where the other prisoners could view and question them freely. It was more than satisfying to see the enemy's facial contortions when they discovered that their comrades were not dismembered, but had their limbs set in good casts, and that they were apparently very much alive and happy. Many questions bombarded the supposedly mistreated victims, and because I was interested, I requested a South Korean interpreter to give me, as verbatim as possible, the meaning of the flurry of words that was ricocheting through the room. It went something like this:

"What did they do to you?"

"They fixed my leg"

"Are you sure you have a leg underneath that white rock?" (They were speaking of the cast.)

"Of course, I have a leg. I can feel it, can't I?"

"What did they do to you first?"

"First, one of their women shows me that I am going to sleep." (He goes through the motion of closed eyes with folded hands against the side of his face.) "Then the Doctor - I think that's him - smiles and motions to my leg, showing he will fix it. I am afraid. I motion will he cut it off? He shakes his head 'No'. Then the woman puts me to sleep and here I am feeling good!"

"How do they put you to sleep?" Another prisoner asks.

"I lay down, the woman shows me to breathe deep and then she covers my eyes with a cloth. Then she puts some funny thing on my nose and I start breathing like she shows me."

"Then what - you go to sleep?"

"N-no - not right away. This stuff smells. I feel that I can't breathe. I fight a little, but that woman she keeps pouring the spirits in my nose and first thing you know - I wake up!"

"You mean you did not feel them fix your leg?"

"No, I feel nothing! They wake me up - I look quick to see if my leg is there, and you can all see - it is there - my leg, it is all there!" He laughs at himself and at the others. Just about the time this fellow finishes his recital, another stretcher is brought in and they quiz the new patient all over again.

It took four patients to convince these poor, miserable, duped communists that they were about to get the best medical care that they have undoubtedly received in all of their lives. Then we could not stop them! They started clamoring for care "Huba, huba." It has always been the policy of our hospitals to take the most serious cases first, but the POWs wanted no part of that practice. They belonged to the school of "first come, first served." As we pursued our method these men would become very upset. It made no difference if their comrade had just arrived with a splintered, mashed, bloody stump and was practically bleeding to death - he had just arrived - their minor scratches had been there five or six hours, so they were first! That is to say, they THOUGHT they were first! When we ignored them temporarily, these strange soldiers would actually pout. This about face of the North Koreans was our most surprising contact with the enemy. We were in for many more new and diverse surprises. A

We must have been in Taegu during the monsoon season (if they have one in September) for when the weather was not sizzling, it was pouring rain. When the rain abruptly stopped, the sun was there frying us; it was as if the sun and rain were playing "Red Light, Green Light." In the deluge, little rivulets of water would snake themselves on the tent's ground floor. Dirt embankments had been dug around the tents, but that did not stop the persistent flow of water. Fortunately, we had Army cots for the patients, so they were not made uncomfortable by these conditions. The tents were absolutely rain tight. Only the Doctors, nurses, and GIs had to walk in oozy, clinging mud. We took it in our stride, derided the mud and thanked the U.S. Army for our field boots. They were absolutely our best friends.

Did we tell you that the Koreans are completely amazing people? We did? Well, let us reiterate - they are positively amazing and the Army nurses and doctors who took care of them are even more so!

The prisoners came to us when there was no longer any doubts in their minds, or in our minds, that they were of no consequence in further combat. Huge, dirty, more than often gangrenous wounds had ripped the flesh of their legs, shoulders, abdomens or chests. We encountered many head wounds in which the prisoner had literally been scalped by shrapnel. The arms and legs that were not gangrenous had fortunately been invaded with maggots. There was one big difference between the UN troops and the enemy - the Allied soldiers received almost immediate care; the Koreans would not see a medical station until captured - sometimes for 15, 20 days. When we received them, good surgery and excellent nursing care saved them. Apart from this fact, their stamina and stoicism are undoubtedly far superior to the Occidentals. Let me give you an example I experienced.

A North Korean POW was brought into our medical tent at 9:00 A.M. with a distended abdomen, rapid, thready pulse, grey pallor, and shallow respirations. He was diagnosed as shock and possible acute pancreatitis. An intravenous was started immediately and the greatest possible medical and nursing care was given this patient. At one o'clock in the afternoon, he appeared dead. I checked his pulse - no pulse. I checked for his heart beat with a stethoscope and I was unable to hear even the barest sound. His body was cold and no evident respiration was noted. The thing to do was to contact a doctor quickly. I went to the main section, as rapidly as possible, slithering and sliding in mud, encountered Captain Baird and told my story. We both scramble back to the tent in double time. Captain Baird entered first. "Which patient is it, Lt. Genest?" I started to point and stopped, flabbergasted. My patient was sitting up drowsily putting his fingers in and out of his mouth, showing us that he was hungry!

I stared at the patient.

"Is that the POW?", queried Captain Baird.

"Ah, ah, ah, y-e-s, sir", I answered, still staring.

"He looks like he's hungry", mused the Captain.

"He does for a fact, doesn't he?", I muttered, still staring.

"Doesn't look too dead, does he?", persisted the Captain, a mischievous gleam lighting his grey eyes.

"Nnnno, no, he doesn't, does he?", I still stared.

"I think he'll be all right, Lt. Genest, I wouldn't worry about him - he probably has nine lives anyway. Hmmm, no pulse, no heart beat, cold skin...you can tell a pulse, can't you, Lt. Genest?", his eyes crinkling in laughter.

"Yes, doggone it, I can, sir!" I snapped back, blushing a fiery red.

He left, grinning, and I have never dared report another North Korean as "apparently dead" until rigor mortis set in. That is one incident, but basically they were all the same. Two or three days of proper medical care, nursing care, food, and they were almost as well as new, no matter how devastating the wound might be!

We were never able to fully reconcile ourselves to watching these men eat. At first, we wondered about their diet, for we knew that they lived on rice, fish and their many peculiar vegetables. We should never have given it a thought. They ate the same rations we did, except that these POWs "wolfed" it down in mouths full and then proceeded to steal the food from their comrades. It took police action on the part of the nurses, M.P.s and ROKs to make these men keep their hands in their own food and not that of their weaker brethren. The food was "C" rations - highly concentrated, very filling victuals. Even GIs with enormous appetites could eat only one plateful at the most. But these communists - they would eat and eat and eat! Twenty minutes later they would stop the nurse and point to their mouths, using the three fingers of both their hands which designated that they were hungry - or they would repeat "Chop, chop, chop, chop." Never, never again do we expect to witness such appetites as these North Koreans have.

The sanitary habits of these communists were so horrible as to be indescribable. They were filthy and desired to remain in this condition. To give these people a bath required constant beckoning, almost divine patience and often half threats. The Koreans would regard these basins sullenly and ignore them completely.

The North Koreans refused to remove their pest-ridden clothing from their backs. Heaven knows we wanted no part of their clothing, but they seemed to fear that we would steal their dirty rags. We tried to explain, by means of our interpreter, that we wanted only to delouse their clothing, but they were adamant to this suggestion. It ended up that we DDT'd them - clothes and all.....

"Lt, do you have a Reader's Digest or a Time magazine, maybe?"

Lt. Mary Bradley of Oshkosh, Wisconsin, stopped stock still - she looked around, wondering whether she was having delusions of hearing, when she met the bright brown eyes of a middle aged prisoner of war. "Did you say something?", she asked, half afraid of making a fool of herself. After all - Koreans speaking English; she just hadn't encountered any!

"Yes I did, ma'am," "I asked if you had a Reader's Digest or a Time magazine, maybe?"

"Where did you learn to speak English, for goodness sake?" Lt. Bradley was staring at him round-eyed.

"I taught English at Seoul University for many years. I studied English and took a degree in education at Oxford University in England."

"Come to think of it, you do speak with that clipped accent. Oxford, Hm...."

"I beg your pardon?" he asked.

"Hm - nothing - I'm sorry. You really startled me. I'll see if I can find anything for you to read."

The Professor, as we nick-named the North Korean, read every bit of literature that we were able to scrounge. He was very helpful, very courteous (one of the very few North Koreans we found with any gratitude in their nasty bones) and would gladly assist us as an interpreter. It

was not up to us to question him, but he certainly aroused our curiosity. We often wondered about him. He would deluge us with questions about the United States. We answered readily -- not the peaches and cream stuff that the United States was a Utopia -- but why we loved America, our people, our politics and our freedom to say "Yes" or "No" or "Why".

He would listen, nod his head in assent at intervals, but about himself, we learned nothing - absolutely nothing.

In our admission tents we had a good routine worked out to handle the huge number of POWs whom we admitted every day. They were brought into the tent, searched for weapons (they were allowed to keep all the rest of their personal effects) and, after clearance, sprayed with DDT. Then each patient would receive a shot of penicillin given by a nurse or an aidman. When this duty was performed, their wounds were examined and the prisoners were placed in sections according to the severity of their cases. The doctor was then called and the patients were checked by him. Following the doctor's instructions, the communists would either be led or litter carried to the medical or surgical tents. The admission tents were then GI'd (cleaned) awaiting the next group of prisoners. This routine was maintained on a 24-hour basis.

Tetanus cases are very numerous among the North Koreans. This shocking disease is not seen in the allied troops because our armies are inoculated to prevent any such occurrence.

These tetanus cases were brought to us in various degrees of spasms. Many were already rigid, with eyes turned back in their sockets, saliva constantly drooling from their mouths, heads bent so far back the skin on their necks was tightly drawn - almost to the bursting point. The medical and nursing care of these communists was terribly difficult, but it was done in the spirit to which doctors and nurses have dedicated themselves.

Despite the adverse conditions, the tremendous workload, and the responsibility of caring for these enemies, if called to perform the same duties again, we would do it most willingly. Not only did we profit professionally from our contact with these prisoners, but also we felt we were showing democracy at work before these communists. They not only beheld and felt the force of excellent medical and nursing care, but witnessed the acts of mercy and humanity that democracy extends to its enemies as well as its citizens.

VI. Long-Distance Ambulance Haul

Members of the 559th Medical Ambulance Company believe their unit holds the long-distance ambulance-haul record for Korea.

One platoon was attached to a division during its advance to the Yalu River. Unit ambulances covered an evacuation route from the advance division clearing station at Kapsan to a mobile surgical hospital at Puk'chong (117 miles) and from Puk'chong to an evacuation hospital at Hamhung (85 miles). The use of ambulance loading posts along the narrow winding mountain roads was impracticable because of guerrilla activities and infiltration tactics of the enemy. Familiarity with small arms was a definite asset to the ambulance driver. It was not uncommon for them to be pinned down by enemy fire with units that they were serving, whereupon it became necessary for them to shelter the patients, dig in and fight with the infantry.

VII. New Military Hygiene and Sanitation Regulations

1. AR 40-205, Military Hygiene and Sanitation, dated 31 December 1942, has been superseded by a much shorter AR 40-205 dated 27 November 1950 and a series of Special Regulations. The AR states the basic policy on this subject and the SRs provide detailed instructions for implementing the policy. The following SRs have been received to date:

- SR 41-20-5, Barber and Beauty Shops
- SR 41-20-10, Trailer Camps
- SR 41-30-1, Food and Beverages
- SR 41-30-2, Cooking and Eating Utensils
- SR 41-60-1, Personal Hygiene
- SR 41-90-1, Waste Disposal

2. Important changes in the new regulations are as follows:

a. SR 41-20-5. Barber and Beauty Shops

(1) Monthly physical examinations for barbers and beauty operators are no longer required. Pre-employment physical examinations are required and special examinations will be made at the discretion of the Surgeon.

(2) Cuspidors are prohibited.

(3) Barbers are prohibited from serving patrons with infectious conditions of face or scalp, or patrons who are infested with head lice.

(4) A disinfecting procedure for instruments used on a person suspected of having a communicable condition has been added.

b. SR 41-20-10. Trailer Camps

Entire SR is new. It outlines the sanitary regulations pertaining to trailer camps located on military reservations.

c. SR 41-30-1. Food and Beverages

(1) A paragraph(3 f) has been added to provide instructions on the use of foods of questionable quality. This covers food of animal origin, fresh fruits and vegetables grown on areas fertilized with human excrement, and canned foods with abnormal tastes, odors, or appearance.

(2) Paragraph 3 g specifies special precautions to be observed in the preparation of foods which readily support bacterial growths.

(3) Paragraph 3 h outlines requirements to be met in serving milk.

(4) Paragraph 3 i provides for sanitation of automatic vending machines.

(5) Monthly physical examinations of permanent food handlers are no longer required. This change is interpreted in the Far East Command to alter in no way the current policies and practice and for periodic examination of indigenous personnel food handlers. The new regulation requires a pre-employment physical examination and specifies the standards of the examination. It also requires a daily inspection of all personnel at the start of the work period.

d. SR 40-30-2. Cooking and Eating Utensils

The number of persons who may utilize a given mess gear washing line is now limited by the requirement that there must be at least one (1) quart of water in each of the three containers for each mess gear to be washed.

e. SR 41-60-1. Personal Hygiene

(1) Foot baths will not be used.

(2) Use of duck boards in showers as a safety measure is optional.

f. SR 41-90-1. Waste Disposal

(1) The use of odor masking devices in latrines is prohibited.

(2) Paragraph 4 c was added to provide instructions for the disposal of laboratory and industrial wastes.

(3) The section on manure has been eliminated.

All medical and MSC officers should become completely conversant with these new regulations. This is particularly important for those whose duties include the provision of advice and guidance on matters of sanitation and the performance of sanitary inspections.

PROPER PROCEDURE FOR SMALLPOX VACCINATION*

A highly virulent form of smallpox has been endemic and epidemic in Korea at intervals during the past several years. There were large outbreaks in 1946 and again in 1948. (A large number of cases occurred among American personnel stationed in Korea in 1946). Strict attention to satisfactory smallpox vaccination will be required to protect troops in Korea and other areas in the Far East Command.

The procedure of smallpox vaccination is not to be undertaken lightly nor with the idea that it requires neither skill nor attention. The contrary is true. It is only successfully performed vaccinations that protect against smallpox. A poorly performed procedure, not correctly interpreted, is worse than useless in that it gives rise to a false sense of security.

Prior to the application of the vaccine, the arm should be prepared by washing with soap and water and thoroughly dried. Ether or acetone may be applied to the area but it must be allowed to dry completely before the vaccine is deposited on the skin. It is extremely important to emphasize that alcohol or other skin antiseptics should never be used in the preparation of the vaccination site. Such antiseptics tend to inactivate the virus and hence, reduce the probability of a successful vaccination. For accomplishment of the vaccination procedure, the multiple pressure method should be used. In applying this method, it is to be clearly understood that the needle is to be held essentially parallel to the skin and the side of the needle point pressed through the drop of the vaccine and into the skin about 30 times. A little resistance should be felt as the needle point is raised and no blood should be drawn. A common error in this procedure is made when the needle is held perpendicular to the skin rather than horizontal and the point then applied directly, thus making multiple "punctures" rather than multiple pressures. It is the MULTIPLE PRESSURE AND NOT the multiple puncture method which is now accepted as being the most satisfactory procedure for the application of smallpox vaccine. Excessive trauma interferes with the proper interpretation of the vaccination reaction.

The area of the vaccination should be kept small. There is no proven relationship between the size of the reaction produced and the degree of immunity resulting. An area approximately 1/8th inch in diameter is considered satisfactory.

Proper Procedure for Smallpox Vaccination, Cont'd:

No dressing should be applied following vaccination. Complications to vaccination, rare as they are, occur much more frequently in the presence of a dressing than when none is used.

It should be continually emphasized that smallpox vaccination properly performed and interpreted will prevent smallpox but that to accomplish this purpose the procedure must not be routinized to the extent that meticulous care in its accomplishment is sacrificed. It should also be emphasized that, if there is known or even suspected exposure of an individual or group to smallpox, revaccination should be accomplished at once without reference to previous vaccination history. The procedure requires little time and negligible disability results. It should be clearly understood that while the occurrence of an immune reaction signifies a certain state of immunity in the individual concerned the production of this reaction will, in itself, stimulate the immunity already present and thus build it to a higher level.

Proper interpretation of the reaction produced following smallpox vaccination is perhaps the single most important feature of the entire procedure. Failures of vaccination should not result if potent vaccine is used and the method of its application is correct. However, on occasion, factors beyond the control of the vaccinator may cause a failure. When this occurs, revaccination is to be accomplished as many times as necessary until a satisfactory result is obtained. If the failure is not noted, however, and the necessary revaccination is not accomplished, the individual concerned may well be completely unprotected. In such an instance, the medical officer responsible for the conduct of the vaccination is entirely responsible and can be judged only as failing to perform his professional duty. An occasional failure to obtain a satisfactory reaction after vaccination may be justified. That such failure be unrecognized cannot be justified.

Great emphasis should be given to the fact that a definite reaction must occur and must be observed before the vaccination can be considered as satisfactory. The absence of a reaction must, in all instances, be interpreted as a failure of vaccination. In no instance should the word of the vaccinated individual be taken as to the presence or absence of a reaction. The interpretation must be made by a medical officer himself or an individual in whom he has complete confidence and whose word he is completely willing to accept. The responsibility, however, lies directly and entirely with the medical officer concerned. It is apparent from the occurrence of smallpox

Proper Procedure for Smallpox Vaccination, Cont'd:

during World War II that failures on the part of medical officers to interpret smallpox vaccinations accurately and to revaccinate when indicated have resulted in numerous cases and deaths from this disease.

The reactions which follow a successful vaccination are vaccinia or primary reaction, vaccinoid or accelerated reaction, or immune or immediate reaction. These are adequately described in TB MED 114, November 1944. They are also well described and illustrated in the text "Military Preventive Medicine" by Dunham, published by the Military Service Publishing Company. Every medical officer should be completely familiar with these various reactions and have a full knowledge as to their significance. Most important of all, every medical officer should be completely aware of the fact that a successful vaccination is always followed by one or the other of these reactions. No reaction at all means that the vaccine was impotent or that the procedure was performed in an unsatisfactory manner.

No vaccination should be considered to have been completed until interpreted and the type of reaction recorded on the individual's immunization register. In general, vaccinations should not be performed unless it is known that the individual to be vaccinated will be available for a period of at least one week during which time the necessary observations may be made. If, at any time, it is impossible to comply with this general rule, it is incumbent upon the officer responsible for the performance of the vaccination to arrange for satisfactory interpretation and recording by a competent and reliable individual. The medical officer's initials following a smallpox vaccination entry on the immunization register indicates not only that the vaccination was performed but also that a satisfactory result was obtained.

Key points of importance in the conduct of successful vaccinations may be summarized as follows:

- Use of potent vaccine shipped and stored under proper conditions (at freezing temperatures or directly on ice).
- Use of vaccine within its expiration date.
- Proper preparation of the vaccination area.
- The multiple pressure method of vaccination, correctly executed.
- Proper interpretation of the vaccination result.
- Recording and certification of the vaccination reaction.
- Repetition of all unsuccessful vaccinations.

Proper Procedure for Smallpox Vaccination, Cont'd:

* This article appeared in the FEC Surgeon's Circular Letter dated 1 September 1950. Since its publication a number of cases of smallpox, some of them fatal, have occurred among U. S. and other UN forces in Korea. All the U. S. services have been affected - Army, Navy, Air Force and Marines. Further cases can be prevented by careful and diligent attention to the accomplishment of successful vaccinations.

It must also be borne in mind that individuals vaccinated after exposure to smallpox, must not be considered to be protected unless a definite immune type reaction occurs. Such individuals responding to a vaccination with a primary or vaccinia reaction may well develop smallpox as well. It has been demonstrated many times, and most recently in one of the cases in Korea, referred to above. Known exposures to smallpox who exhibit a primary vaccinia type reaction to vaccination must be segregated and observed for at least sixteen (16) days following vaccination in order to rule out the possibility of the presence of smallpox which may be incubating simultaneously with the vaccinia type reaction.

VIII. Technical Recommendations for Small Medical Units Using X-ray

In order to conserve films and be of some possible assistance to field medical units who do not have a qualified Roentgenologist, the following minimal procedures are suggested by Lt. Colonel H. C. Harrell, MC, Consultant, Radiology, FEC. All references are to TM 8-280 (Military Roentgenology).

Hand:

PA and oblique (1-8 x 10)
Pages 145 and 147

Wrist:

Pa and oblique (1-8 x 10) NOTE: The oblique is of particular value in studying the navicular. A lateral wrist is seldom required.

Forearm:

AP and lateral (1-10 x 12)

Elbow:

AP elbow extended - Lateral elbow flexed (2-8 x 10) or (1-10 x 12) (Pages 169 and 165)

Humerus Shaft:

AP and lateral (1-10 x 12)
(Pages 169 and 171)

Shoulder:

(for injury) AP (1-10 x 12) Lateral and/or obliques as indicated.

Shoulder:

(For other than injury) - 2 AP's - One with humerus in internal rotation and the other in external rotation. (Particularly valuable to demonstrate extraneous calcification around the joint.)

Foot:

AP and oblique (Pages 183 and 185)
(1-10 x 12)

Calcaneus:

PA and lateral (Pages 189 and 193)

Ankle:

AP and lateral (1-10 x 12)

Leg:

AP and lateral (1-14 x 17)

Knee:

AP - knee straight. Lateral - knee flexed (2-10 x 12)

Shaft of femur:

AP and lateral (Use portable grid)

Hip:

AP - thigh in normal position; AP - thigh abducted if practicable (2-10 x 12)

Both Hips:

Same position - (2-14 x 17) (Page 217)

NOTE: Use portable grid for all hips, pelvis and spine x-rays.

Pelvis:

AP (1-14 x 17)

Sacrum:

AP and lateral (2-10 x 12) Use grid.

Lumbar spine:

AP and lateral (2-14 x 17 with grid) NOTE: Use cone and 12 x 12 films over areas of question.

Dorsal spine:

AP and lateral (2-14 x 17) NOTE: A good lateral of upper dorsal spine is impossible. Use two obliques with cone and small films when a decision has to be made in this area.

Cervical Spine:

(Grid not used) AP (1-8 x 10) Lateral (1-10 x 12) (Pages 241 and 245) NOTE: The open mouth position AP should be used when pathology is suspected about the first or second cervical segments - Page 243

Ribs:

AP and PA (2-14 x 17) (Use grid)

Skull:

PA, Rt and Lt - lateral and fronto-occipital (4-10 x 12) Use grid. (Pages 261-265-267)

Mandible:

Rt and Lt oblique and PA (3-8 x 10)

IX. Army Medical Service Cataloging Research Scientists - DA, SGO Technical Information Office

Taking a further step in better utilization of manpower, especially that of the scarce and highly technical kind, The Surgeon General's Office is cataloging every applicant commissioned in the Medical Corps for the purpose of finding those who have training or experience in research.

The Surgeon is interested in knowing just what medical talent is available for research in clinical and investigative work and this takes in the related fields of bacteriology, chemistry, physiology, etc.

The Medical Research and Development Board of The Surgeon General's Office has prepared a special questionnaire which is given to selected individuals after they have reported for duty at the Medical Field Service School, Ft. Sam Houston, Texas, where definite assignments are made.

Individuals with particular qualifications in research for which the Army has definite need are being placed in research assignments. The questionnaire of those for whom there is no immediate assignment is held by the Research and Development Board for future openings.

X. Recent Department of the Army and FEC Publications



AR 40-100, 3 Jan 51: Medical Service - Standards of Miscellaneous Physical Examinations

SR 40-1025-50, 15 Dec 50: Medical Service - Evacuee Report Card (RCS MED-75)

SR 605-25-10, C-1, 22 Jan 51: Officers - Appointment in MC, DC, VC, MSC, ANC and WMSC, Regular Army

SR 350-230-60, 1 Feb 51: Education and Training - Tentative Courses at Civilian Educational Institutions for Officers of the Army Medical Service - Fiscal Year 1952

TB MED-195, 4 Jan 51: The Army's Audiology and Speech Correction Program for the Deafened

TM 8-500, AFM 160-8, Jan 51: Hospital Diets

T/O&E 8-26, C-2, 6 Dec 50: Hqs & Hqs Detachment, Medical Battalion, Separate

PART II

TECHNICAL

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AI. Treatment of Frostbite - Consultants Division, Medical Section, GHQ, FEC



In order to insure uniformity of classification the following should be used in all cases of frostbite occurring within this command:

- Class 1. Hyperemia
- Class 2. Hyperemia with vesicle or blister
- Class 3. Necrosis of subcutaneous tissue

The following plan of management should be instituted as far forward as possible:

1. No smoking - for all patients
2. Strict bed rest on all foot cases as ordered by doctor.
3. Keep sheets above knees, or raised above feet.
4. Daily foot paint with zepherin (1:1000 dilution, colorless).
5. Bed blocks as indicated (gangrene).
6. Keep ward temperature down to 78 degrees, or lower
7. Regular diet.

Routine Care on 2d and 3d Degree Involvement:

1. a. Intravenous frostbite solution (FEC) should be started as early as possible and continued at the rate of one flask per 6 hours throughout the chain of evacuation. All cases of frostbite without other injury should receive this solution after 100 mg of heparin⁽¹⁾ (supplied with containers of the solution) has been added, prior to intravenous injection. Cases of frostbite with other injuries should receive added heparin at the discretion of the local medical officer.

b. The 23-gauge needle affords the proper rate of flow and no other needle should be substituted.

2. Penicillin 300,000 units as ordered by doctor.
3. Nicotinic acid 100 mgm t.i.d.
4. Multivitamins X 2 daily.
5. Tetanus toxoid booster 1 cc.
6. Strict bed rest unless ordered otherwise by doctor.

Routine Care on 1st and 2d Degree Involvement and Ambulatory:

1. Penicillin 300,000 units daily for two days after admission.
2. Nicotinic acid 100 mgm t.i.d.
3. Multivitamins tablets 2 daily.
4. No restriction on latrine and shower facilities.
5. Patients make own beds and police their immediate areas.

Heparin should be utilized as early as possible after frostbite because of its action as noted in the referenced proceedings. The instructions which will be on each 250-cc flask are quoted below:

INTRAVENOUS FROSTBITE SOLUTION

FEC

Contents Formula:

12 cc ethyl alcohol
250 mgm procaine hydrochloride
5% glucose in water to make 250 cc

1. For frostbite
2. Dosage: Contents of this flask (250 cc) repeated every six (6) hours.
3. Instructions:
 - a. Start treatment as early as possible after each diagnosis.
 - b. For frostbite cases with other wounds give solution as prepared
 - c. For frostbite cases without other wounds 100 mgm heparin will be added to each 250 cc of the solution prior to the administration.
 - d. Make entry on EMT or FMC giving date and hour of each dose. If heparin has been added include entry "heparin added".
4. Caution:
 - a. Use only the 23-gauge needle provided with the set.
 - b. In doubtful cases, heparin will be used only at the discretion of the local medical officer

(1) Proceedings of the Society for Experimental Biology and Medicine, May 1950, "Prerequisites of Successful Heparinization to Prevent Gangrene After Frostbite", by Kurt Lange, Linn J. Boyd, and David Weiner.

XII. Medical Problems in Obstetrics - Col. F. W. Pruitt, MC, Medical Consultant, Medical Section, GHQ, FEC

Perhaps the greatest interest and by far the most commonly involved system in obstetrics is the cardio-vascular, medically speaking. The ramifications of obstetrical cardiology are rather broad and at times tax the ingenuity and judgment of the internist and his obstetrical colleagues alike. The application of modern methods of diagnosis and therapy of heart disease in the institution of a systemic control of cardinals who may become pregnant has decreased the maternal mortality among cardinals during the past ten years from about 20% to about 3%, according to Stroud.

The current figure of the American Heart Association in their publication brings this mortality to a still lower level, about 2%. The latter figure includes those in failure. With rare exception the normal heart has ample reserve to carry the increased load brought about by child-bearing. This increased load is obviously brought about by increase in weight, additional muscular strain, and other demands resulting from shifting hemodynamics, such as increased pressure on the diaphragm by an enlarging uterus, etc.

Caloric requirement of the fetus and mother may not exceed the normal capacity of the heart but the mechanical effort of supplying a large additional vascular bed may be considerable. Plasma and total blood volume are increased during pregnancy and fall soon after delivery. It begins early in pregnancy and reaches its maximum of about 45% above normal one month before delivery. Then the plasma and total blood volumes decrease to about 30% above normal at term. The hydremia of the blood is accompanied by hydremia of all the tissues. This fact is important in the development of congestive heart failure during pregnancy. Increase in cardiac out-put is demonstrable from the 12th week of pregnancy. It increases slowly until the 24th week, then rapidly to the 36th week, when it reaches its maximum. From then on it decreases somewhat until term and more rapidly after term. No explanation has been given for the pre-delivery decrease, but it is an important integral part of pregnancy. It has practical therapeutic significance as the heart is then under maximal strain and it is not the time to interrupt pregnancy.

Many of the so-called murmurs of pregnancy are undoubtedly ordinary functional murmurs discovered during pregnancy. Some, however, do seem to be associated with the pregnant state.

Specific Types of Heart Disease:- Congenital Heart Disease: As a group, pregnant women who have congenital heart disease run the risk common to other forms of heart disease: congestive failure and subacute bacterial endocarditis, but some of them present the danger of reversal of the blood stream, that is venous arterial shunt, immediately following labor or sections, which has proved fatal in a number of cases. Cyanosis, when marked, constitutes a contraindication to pregnancy. Congenital difficulties of the heart which increase its work may lead to congestive heart failure. Their course is associated with hypertrophy of those chambers which are under strain. Women with auricular septal defects can generally accomplish child-bearing. This is the lesion, which when severe, may lead to venous-arterial shunt. Patent, ductus arteriosus involves three risks, (1) congestive heart failure, (2) sub-acute bacterial endocarditis, and (3) venous arterial shunt. Congestive failure is the natural termination for patients with this lesion. If the cardiac reserve is ample the outlook is good, because the other two risks rarely materialize. Isolated septal difficulties generally present a favorable prognosis although they are peculiarly susceptible to bacterial endocarditis. Pulmonary stenosis frequently associated with ventricular septum and other difficulties, is often associated with cyanosis and might be expected to be a serious threat to pregnancy.

Coarctation is not a contraindication, but should be seriously evaluated before pregnancy is undertaken after the age of 30. Other congenital difficulties are of little interest to the obstetrician. They are either insignificant, undiagnosed, or incompatible with conception. Other than the congenital lesions just mentioned and a few patients with hypertensive and leucic heart disease the overwhelming majority, about 90% according to Stroud, will be found to have rheumatic valvular disease. In a group with simple mitral stenosis it may be properly classified as one of rheumatic valvular disease or chorea. If there is no diastolic murmur and no other sign of mitral stenosis it may be properly classified as one of mitral regurgitation. When such cases are well compensated and show no subjective or objective evidence of congestive failure for obstetrical purposes they may be regarded as normal women for the maternal mortality will be about 1%. Some in this group may show auricular fibrillation. A second group will show definite evidence of mitral stenosis or aortic valvular disease. This group is the most important group of all for here the problem of congestive heart failure arises and there will be significant maternal mortality. With rare exception the normal heart has ample reserve to carry the increased load. In pregnant women with heart disease failure develops as pregnancy advances, but if they are capable of carrying the pregnancy to the 36th week their hearts rarely fail near term, during labor or in the puerperium. Evidence of early decompensation must be foremost in the minds of both the internist and the obstetrician in the care of the pregnant woman with mitral stenosis or aortic valvular disease. Dyspnea on exertion in previous experience, cough on effort, rales in the bases of the lungs, or early fibrillation must be recognized early and given appropriate treatment. A reduction of vital capacity is a very reliable index. If decompensation is absent pregnancy may be advised, or the patient be permitted to continue if already pregnant. In this type of heart disease with a history of decompensation or present evidence of failure or persistent fibrillation, pregnancy must be avoided or interrupted. The advantages of early and frequent prenatal examination, from a cardiac standpoint, provides a basis on which a decision may be made. That is whether the patient should be permitted to continue or whether the pregnancy

should be interrupted. If interrupted during the first few weeks it is a comparatively simple procedure, whereas later in pregnancy it is a major one. In the absence of decompensation or other clinical manifestations of heart disease all cardiacs should be permitted to continue their first pregnancy. If a normal child is obtained with a noncomplicated pregnancy they should be urged to have a second child within two years. Pregnancies beyond this may be entirely optional with the parents. Although many cases of mitral stenosis have gone through multiple pregnancies the general feeling is that more than three pregnancies in this type of heart disease are contraindicated and contraceptive measures should be used or serious consideration given to interrupting the pregnancy based on the criteria given previously. Sterilization should not be performed at the first pregnancy, as this child may not survive and the procedure should not be carried out until the parents are fully satisfied with the number of children living.

Pardee's figures are noteworthy. He reports no death among 157 organic cardiacs who showed no evidence of failure on considerable effort. One death in 180 with slightly restricted activities, 8 out of 169 who were greatly limited to their response to effort, and 16 out of 40 who were essentially bed-ridden. Other authors report similar results.

Sir Thomas Lewis feels that most cardiacs can be carried through a pregnancy unless there is venous congestion with or without auricular fibrillation, in which case the uterus should be emptied early. Cardiac arrhythmias other than fibrillation do not usually endanger pregnancies. Ventricular premature contractions (extrasystoles), are insignificant. A V block is usually of a more serious nature and the underlying cause should be investigated. Bundle branch block generally contraindicates pregnancy. Digitalis may be useful in controlling cardiac arrhythmias of pregnancy, and is preferred to quinidine which has a definite oxytoxic action and may precipitate uterine contractions.

The Relation of Maternal Infection to Congenital Malformations of the Heart: Herbert C. Miller, M.D., in "Modern Concepts of Cardiovascular Disease" presents the following:

"The problem of preventing congenital heart disease has received great impetus from the remarkable observations made by Gregg in Australia. An unusual number of children with congenital cataracts, associated in many instances with congenital heart disease, presented themselves in Sidney in the early months of 1941. Gregg discovered that one of the factors common to this group of children was the fact that their mothers had contracted German measles (rubella) during the early weeks of their pregnancies. The maternal infection coincided with an epidemic of German measles which occurred in the civilian population and army encampments alike. These initial observations were quickly confirmed by physicians in the United States and Europe, as well as Australia, so that by now many hundred cases have been reported.

"The types of congenital defects that have been found in children whose mothers contracted German measles early in pregnancy include, in addition to those of the eyes and heart, deafness which is either partial or complete and may be bilateral, mental retardation that is often severe, a small body size at birth and a failure to grow and develop physically at the expected rates. A large number of other defects are less commonly seen, such as cleft palate, harelip, inguinal hernia, glaucoma and occasional genito-urinary anomalies. It is known that some babies whose mothers contract rubella in the first three months of pregnancy escape without having any evidence of a malformation, but it is not yet established how often this fortuitous result occurs.

"Malformations of the heart are among the defects most frequently observed subsequent to maternal rubella. Approximately 25 to 50% of the children with defects have been reported as having malformations of the heart. Theoretically the virus of German measles traverses the placental barrier and produces an injury to the heart at the time these critical morphologic changes are taking place. Hence an attack of German measles in the second month of pregnancy is likely to involve the heart. On the basis of available data, which admittedly are imperfect, probably about 5% of congenital cardiac defects can be ascribed to maternal rubella. These are of the acyanotic type.

"The only way known at the present time of preventing maternal infection in the first trimester is to expose as many girls as possible to the infection before they have reached the child-bearing period. There is no question that German measles acquired in childhood would be a welcome means of ridding the population of the devastating effects visited on some of the unborn children of mothers unfortunate enough to have acquired this infection in the first three months of pregnancy."

Blood Disease: There is a normal physiological hemodilution of pregnancy. The plasma vol-

ume is increased with a corresponding decrease in red cells. A count of 3,500,000 per ten grams of hemoglobin is normal. Approximately 30% of all pregnancies have an iron deficiency and hemoglobin may be below 10 grams. Frequently blood smears will show a macrocytic anemia resembling that seen in Addisonian pernicious anemia. It has been called the pernicious anemia of pregnancy. These respond well to ferrous sulfate. In sickle cell anemia, pregnancy may cause an exacerbation of the anemia. The percentage of dead fetus is very high as is the percentage of toxemia. Transfusions are of questionable value.

Metabolic Disease: Thyroid. The thyroid gland may undergo hyperplasia during pregnancy either as a simple goiter with no clinical manifestations or a true thyrotoxicosis. The basal metabolic rate is not too helpful as this will normally go to approximately a ± 25 to ± 25 during the last trimester of pregnancy, (sum of fetus and maternal structures), only to return to normal after delivery. In the case of pregnancy with thyrotoxicosis, the latter and not the pregnancy should be interrupted as an uncontrolled Graves' disease may interrupt the pregnancy. A subtotal thyroidectomy, after adequate preparation, may be carried out safely in early pregnancy. Treatment of the thyrotoxic state with antithyroid drugs has been somewhat controversial. However, Sturgis, and more recently Means, do not favor antithyroid drugs because of the possibility of cretinism in the offspring. Within the past year the JAMA carried the report of such a case. Radioactive iodine is safe up to the 12th week as the human fetus does not exhibit iodine uptake until after that time. Previous thyrotoxicosis which has been cured or adequately treated is not a contraindication to future pregnancies unless there is residual thyrotoxicosis. Means feels as a precautionary measure pregnancies should not be undertaken until two years after appropriate measures have been taken to cure a patient of Graves' disease.

Diabetes: The general consensus is that diabetes is more menacing to a pregnancy than is the pregnancy to the diabetes. Insulin has done much for the diabetic woman who is pregnant. Joslin, in 1945, reported 210 consecutive pregnancies in diabetic women with 209 survivals. These are approximately the figures given in other clinics in which the maternal survival is approximately 98% and that of fetal survival approximately 85%. The sudden change in carbohydrate tolerance necessitating dietary and insulin adjustment are, however, unpredictable. The increased carbohydrate tolerance appears to follow at about 6 to 8 months with a return to the original level shortly before term. Nausea and vomiting during the first trimester demand readjustment so that adequate carbohydrate is kept burning to prevent ketosis. Small feedings usually are adequate. Generally speaking, most cases can be adequately controlled by the use of protamine zinc insulin plus regular insulin before breakfast with such extra insulin as may be needed before lunch and evening meal. This rather exacting control not only gives the maternal tissue a more normal physiological basis but also prevents undue demands on the islet tissue of the fetus. There is a feeling that premature delivery in diabetics and still-births may be prevented to some extent by substitutional therapy with estrogen and progesterone. This is to counteract the abnormal rise in chorionic gonadotrophin seen in the blood stream after the 20th week of pregnancy. These patients do not have a normal delivery. Mosenthal feels that (1) pregnancy extenuates an existing diabetes; (2) pregnancy favors the development of diabetes in later years; (3) the average age of diabetic mothers is older, and this is a predisposing factor to stillbirths. In this connection a diabetic, who is 30 years or older with diabetes of longstanding, is a much greater risk, especially for fetal survival, than is the comparatively new diabetic; (4) the demands for thiamin are greater in the presence of diabetes; (5) the indications for a Caesarian section should be left to the judgment of the obstetrician. It is known, however, that these babies are larger than in non-diabetic pregnancies. It seems probable that complete regulation of the diabetic from the beginning of pregnancy will abolish complications to which mother and fetus are liable. As labor approaches, supplemental glucose covered with insulin by vein is recognized as good therapy. Otherwise the patient should be watched during labor with frequent blood determinations rather than urinalyses. Meticulous care should be taken to check acidosis and prevent hypoglycemia in the mother. The occurrence of dangerous hypoglycemia in the newborn may be prevented by controlling insulin administration to the mother.

Glomerulo-Nephritis: This may be dispensed with by stating that each case must be individualized. Pregnancy usually intensifies the nephritis, and they may abort at about the 5th month.

Syphilis and Pregnancy: Goodwin and Faber, in the American Journal of Syphilis, Gonorrhea and Venereal Disease, in September of 1948, in commenting on 596 infants born of mothers who had had prior treatment for syphilis conclude that: Treatment during pregnancy may be withheld provided the mother has previously received 4 gms or more of arsphenamine together with bismuth or 2,400,000 units of penicillin and that she shows no clinical signs of active syphilitic infection and that the serology is negative, or if sero-positive, it is not low titer, (1 to 8 units). A syphilitic mother should be treated in any pregnancy in which she herself shows clinical evidence of active syphilitic infection, or in the absence of such evidence, she has a positive serology in a quantitative titer of 16 or more units. Four million units of penicillin plus bismuth and neocarsphenamine is the recommended therapy.

XIII. Routine Hepatitis Treatment - Addition Thereto

Attention is invited to "PRUITT'S PROTEIN MILK FORMULA", page 10 in the 1 November 50 issue of the Surgeon's Circular Letter. This formula should be amended to include the following:

Casein, edible, (Powdered skim milk or Mead Johnson's Protein Milk or Caseac)	600 grams
Vanilla	5 teaspoonfuls

XIV. Antibiotic Therapy - Consultants Division, Medical Section, GHQ, FEC

The administration of antibiotics in wounded patients is begun in the forward stations and is continued along the chain of evacuation. The fixed hospitals receiving these patients frequently continue with the program without re-evaluation of the patient, his wounds, and the rationale of the antibiotic employed.

Since the use of antibiotics in patients with wounds is to prevent spreading infection, judgment should be exercised in deciding whether the antibiotic actually accomplishes the purpose for which it is given. In a large number of wounds, the continued indiscriminate use of antibiotics is unnecessary and should be discontinued by the medical officer responsible for the treatment of the patient in a fixed hospital.

For patients with suppurating wounds which are not responding to the antibiotic employed, the indications for supplementary surgery must be considered and for giving another antibiotic to which the flora of the wound are susceptible. Surgery may be indicated to establish dependent drainage and to remove foreign material and devitalized tissue which provide a culture medium for the organisms. Because many of the organisms in a wound are resistant to the antibiotic administered, culture sensitivity tests in selected cases should be employed to determine which of the available antibiotics could be expected to be of value in therapy.

XV. Aureomycin Treatment of Granuloma Inguinale - Capt. Robert L. Guillaudeu, MC, Third Platoon, 629th Clearing Company Separate

Several cases of chancroid or Granuloma Inguinale have been seen at sick call. The response to Aureomycin has been much better than the response to sulfadiazine.

Chancroid is said to cause three times as many genital sores as syphilis. The incubation period is short usually less than a week. The first symptom is pain incident to chafing by clothing. At this time an inflammatory macule is noted, which may be anywhere on the penis or scrotum, and may be multiple. The macule progresses in 2 or 3 days to form a pustule, which soon ruptures forming a ragged ulcer. There is little induration, the lesion being soft with vague edematous thickening. The edge is usually ragged, undermined and bordered by a narrow zone of erythema. The base is covered with purulent necrotic grayish exudate and may be pitted or mammillated⁽¹⁾. The complications we have seen are phimosis and inguinal adenitis.

When first seen the disease was not recognized. Darkfield examinations showed no spirchetes. Gram stain usually showed gram positive cocci and gram negative rods. Culture methods were not available. Treatment with penicillin and hot soaks was ineffective. Sulfadiazine in doses of 1 gm q.i.d brought about some improvement in four to five days.

Aureomycin in doses of 250 mg. q.i.d. brought about a marked decrease in tenderness and inflammation, of the local lesion, within 24 hours. In 48 hours healing had begun. This dose was given for 4 days. No relapses were seen. Inguinal adenitis responded much more slowly.

The author would like to call attention to the disease and to the efficacy of Aureomycin treatment. Since the antiluetic properties of Aureomycin are not known, a darkfield examination should precede its use and a serologic follow up should be made.

(1) "Handbook of Communicable Diseases." Franklin H. Top 2nd Edition 1947. The C.V. Mosby Company

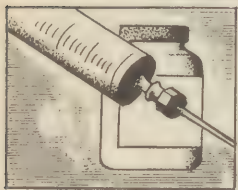
XVI. Artificial Respiration - Consultants Division, Medical Section, GHQ, FEC

The issue of the JAMA for 23 December 1950 has two articles on artificial respiration written by Archer S. Gordon, et al, of Chicago. These are based on carefully conducted experiments in which attempts are made to evaluate the efficacy of various methods. Of the manual methods, they conclude the "Shafer-Emerson-Ivy" offers the best result. The "push-pull" combination may be applied in two ways:

1. Hip-lift-prone pressure: With the patient prone, the operator straddles him as in the Shafer method. The hips are lifted 4 inches, 12 times per minute alternating with the Shafer push on the lower chest. Lifting the hips is fatiguing and after the crucial first several minutes may be used with every second or third push on the lower chest. A belt or a rope about the hips for lifting the patient may be of help to the operator.



2. Hip-roll-prone pressure: This is easier, less fatiguing and may be administered for long periods of time. The patient is prone and the operator is to one side. The knee, fist or hand of the operator must always be placed under the hip close to him. The distant hip is in effect rolled onto the knee, fist or hand. This elevates most or all of the abdominal surface from the horizontal to produce descent of the diaphragm. When the patient has been rolled back to the prone position, the Shafer push is applied to the lower posterior chest.

XVII. Notes on Pentothal and Curare - Consultants Division, Medical Section, GHQ, FEC

Increasing evidence being compiled by anesthetic mortality studies in the United States plus the experiences of the last war indicate that the use of pentothal-curare-nitrous oxide-oxygen anesthesia for major surgical procedures in freshly wounded men, especially those suffering from hemorrhagic shock, is a hazardous procedure.

While this combination of drugs offers some advantages, especially in the reduction of time necessary for induction of anesthesia, it also has some serious drawbacks, namely:

1. High concentrations of oxygen in the inhalation atmospheres are desirable in shocked patients. With the pentothal-curare-nitrous oxide-oxygen technique, 50% or less oxygen is administered to the patient, whereas with ether, oxygen, closed system anesthesia, 95 to 96% oxygen can be administered during the maintenance of surgical anesthesia.

2. The circulatory depressant effect of pentothal is well known and should be avoided in shocked patients.

3. The combination of pentothal and curare is a profound respiratory depressant. While this respiratory depression can be effectively counteracted during the administration of the anesthetic while the patient is under the care of a competent anesthesiologist, it leads to a dangerous situation postoperatively. During the postoperative period, this respiratory depression may well lead to progressive asphyxia which is often insidious in its development and unless the patient is under the constant surveillance of well trained personnel, it is often recognized too late.

In situations where the workload becomes so heavy as to spread thin the personnel available for this close supervision plus other factors inherent in the operation of a forward medical installation during active combat, it would seem advisable to avoid the possibility of this complication.

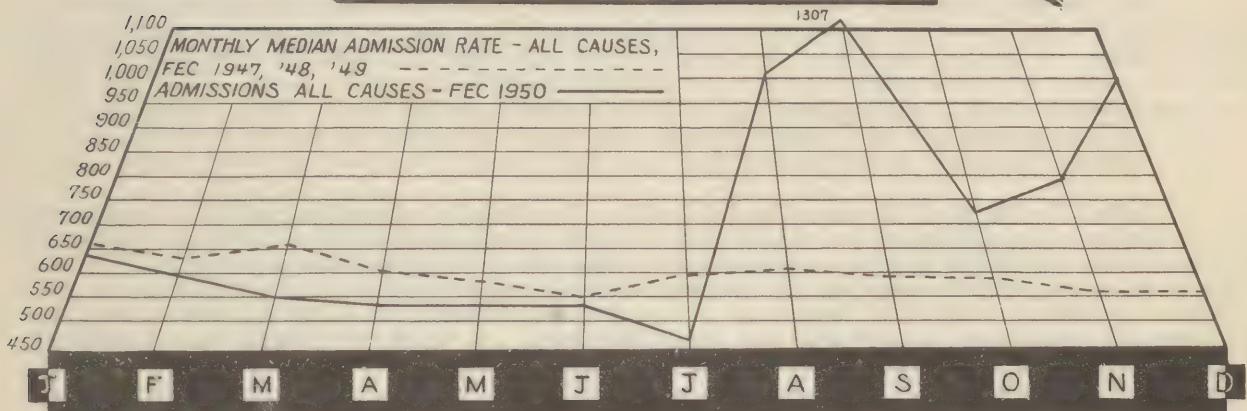
RECOMMENDATIONS:

1. The use of pentothal-curare-nitrous oxide-oxygen anesthetic combinations should be avoided in freshly wounded patients suffering from serious blood loss.
2. The administration of curare should be reserved for specific instances where in the judgment of the anesthesiologist the operation will be facilitated and the deteriorating effect of prolonged deep anesthesia avoided.
3. Curare must be administered by the anesthesiologist (physician anesthetist) or under his direct supervision.
4. It is undesirable to ban the use of curare which has a useful, although limited place in the armamentarium of the trained anesthesiologist.
5. Ether-oxygen anesthesia in closed systems using nitrous oxide or small amounts of pentothal for induction will provide satisfactory operating conditions in the majority of patients. The safety factor and controllability of this combination is not possible with pentothal-curare-nitrous oxide oxygen technique.

PART III

STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the five week period ending 29 December 1950 were as follows:

	FEC	JAPAN	KOREA	MARBO	PHILCOM(AF)	RYCOM
All Causes	996	751	1240	424	449	558
Diseases	648	644	694	355	344	506
Injuries	201	79	300	69	88	52
Battle Casualties	147	27	246	0	18	0
Psychiatric	18	17	21	1.6	19	7.4
Common Respiratory Diseases and Flu	129	181	115	33	31	86
Primary Atypical Pneumonia	5.1	4.4	5.6	0	7.3	4.6
Common Diarrhea	13	1.8	21	0	2.9	6.0
Bacillary Dysentery	.07	0	.13	0	0	0
Amebic Dysentery	.07	0	.06	0	1.5	0
Malaria, new	1.6	.68	2.3	0	1.5	.46
Infectious Hepatitis	8.3	6.9	9.8	0	4.4	6.9
Mycotic Dermatoses	1.3	.34	2.1	0	0	.92
Rheumatic Fever	.36	.34	.44	0	0	0
Venereal Diseases	93	138	58	13	112	187

Data submitted in this Section constitute a complete coverage for Army and Air Forces personnel of the Far East Command for the five-week period in December except Fifth Air Force personnel for the last week. It is felt that the omission of the above personnel has had very little, if any, effect on the rates as submitted herein.

Admission Rates:

In December in the Far East Command, Army and Air Forces personnel were admitted to hospital, quarters and dispensary for all causes at a rate of 996 admissions per thousand strength per year. In comparison with the November rate of 793, this is an increase and results from each of the three components (disease, injury and battle casualty) having experienced increases in admission rates for the month. Of the three components, disease depicts a lesser increase in admission rate than do the other two.

The disease component of the all causes admission rate increased to 648 in December from 610 in November. Of the major commands, only Japan and MARBO experienced increases. For the Far East Command, the increase in incidence rate of common respiratory disease and influenza from 65 for the previous month to 129 for December, and pneumonia from 5.5 to 13, were the only reportable diseases which show a notable increase. In Japan, this group of diseases alone more than accounts for the overall increase in its disease admission rate.

A considerable increase occurred in the Far East Command's nonbattle injury component of the all causes rate for December. The rate was 201 per 1000 per year as against 118 for November. The primary factor contributing to this rate was the increase in cold injury incidence which accounts for 25% of the total cases. Among the major commands, Japan, Korea and PHILCOM (AF) reported increases while MARBO and RYCOM reported decreases. 84% of all nonbattle injuries in the Far East Command for the month occurred in Korea, giving that command a rate of 300 as compared to 163 for November.

The Far East Command's battle casualty admission rate for December increased from 66 for November to 147. In Korea alone, the rate increased from 115 to 246 for the same period. A considerable number of battle casualties were received by Japan directly from the field in Korea. In fact the number was great enough to have increased Korea's rate for the month to 261 had those cases been admitted to medical treatment facilities in that command.

Diseases:

Common Respiratory Diseases and Influenza: The reported admission rate for common respiratory diseases and influenza for the Far East Command increased from 65 per 1000 per annum for November to 129 for December. In comparison, the rates for the same period in 1948 and 1949 were 80 and 58 respectively. This is one of the sharpest increases for this group of diseases so far recorded since the occupation of Japan, and is the highest FEC rate since April, 1947. Among the major commands, MARBO and PHILCOM (AF) had minor decreases, and RYCOM reported a minor increase for the month. The increase of these diseases among personnel in Japan and Korea accounts for the overall command increase. Japan experienced the greatest increase reporting a rise from 64 cases per 1000 troops per year during November to 181 in December. Korea's rates for the same periods were 68 and 115 respectively. For comparison, records, reveal that the rates of these diseases in Japan and Korea for the months of January, February and March 1948 were 144, 135, 144 and 190, 220, 199 respectively. During December, laboratory studies reveal the presence of true influenza among occupation personnel in Japan. While undoubtedly contributing to the overall increase in respiratory diseases, this infection did not occur in epidemic proportions.

Pneumonia: A considerable increase in total pneumonia incidence was reported during December. The FEC rate increased from 5.5 to 13. Of the major commands, Japan and Korea had the greatest increases. The rate in Japan increased from 2 in November to 7.6 in December, while Korea's rate went from 8 to 18 during the same period.

Psychiatric: The incidence of psychiatric conditions remained static for November and December, the rates being 19 and 18 respectively. Of the major commands, PHILCOM (AF), whose rate increased from 7 for November to 19 for December, was the only command to experience a notable change.

Malaria: No significant change was reported in the number of cases of new malaria occurring in the command during December. The rate was 1.6 as against 1 for November. This compares favorably with rates of 2.7 and .48 for the same period in 1948 and 1949.

Diarrhea and Dysentery: The incidence of intestinal diseases infections in the command decreased from a rate of 20 for November to 15 for December. This represents the lowest rate since the beginning of the Korean conflict. 91% of all cases reported were in Korea; however, Korea's rate for the month was 25 as compared to 33 for November, and is the lowest rate since the beginning of the conflict.

Poliomyelitis: 8 cases of poliomyelitis were reported in the Far East Command during December, all cases occurring among personnel in Korea, with no deaths resulting. In summary, this brings the total cases occurring among occupation personnel in the command during the year to 88 with 2 deaths resulting. In comparison, 89 cases with 3 deaths resulting occurred in 1949, and 107 cases with 11 deaths resulting occurred in 1948. A breakdown by major commands reveals that: 39 cases with 1 death occurred in Japan; 29 cases with 1 death occurred in Korea; 14 cases occurred in PHILCOM (AF); 5 cases occurred in MARBO; and 1 case occurred in RYCOM.

Infectious Hepatitis: Following a definite increase in the incidence of infectious hepatitis during November, at which time the rate went from 3.4 for October to 10, the rate decreased to 8.3 for December. The Far East Command's decreased rate is attributed entirely to experience in Korea where the rate declined from 16 in November to 9.8 in December. Japan, PHILCOM (AF) and RYCOM reported moderate increases over the previous month; however, Korea with a rate of 9.8 continues to be the highest among the major commands. In comparison with past experience, it is clearly indicated that the incidence of this disease is increasing in this command.

Venereal Diseases: A considerable decrease in the venereal disease rate for December as compared to November was noted. The rate decreased from 119 in November to 93 in December, and is principally accounted for by Korea's decrease from a rate of 93 to 58. Likewise, Japan contributed to the lower rate by experiencing a decrease from 154 in November to 138 in December. RYCOM's rate continues very high; however, a small decline from a rate of 201 in November to 187 in December was noted.

Deaths: 190 deaths were reported by medical treatment facilities in the Far East Command during December. Of these, 99 occurred among battle casualties, 70 among nonbattle injury cases, and 21 resulted from diseases.

It is planned that in the future, commencing with the January report, medical statistical data as presented in this Section will be on Army personnel only. In addition to the fact that Air Forces have their own medical service now, they have adopted a new reporting system.

Evacuation:

Tabulated below are the number of patients evacuated from the major commands to the ZI during the five report weeks in December and the number of patients awaiting evacuation as of 29 December 1950:

	<u>BY AIR</u>	<u>BY WATER</u>	<u>TOTAL</u>	<u>PATIENTS AWAITING EVACUATION</u>
JAPAN	6,757	19	6,776*	249
MARBO	1	1	2	1
PHILCOM (AF)	20	1	21	0
RYCOM	72	12	84	4
FEC	6,850	33	6,883	254

(*5,997 patients originated from Korea.)

Hospitalization:

The bed status as of 29 December 1950 was as follows:

	<u>Bed Capacity</u>		<u>Operating Beds</u>	<u>Beds Occupied</u>
	<u>Normal</u>	<u>Mobilization</u>		
JAPAN	8,550	9,300	8,550	9,711
KOREA	2,560		10,485 (Incl POW)	1,370 (7,519)**

(** Beds occupied by POW)

Hospitalization (Cont'd)

	Bed Capacity		Operating Beds	Beds Occupied
	Normal	Mobilization		
MARBO	200	300	200	77
PHILCOM (AF)	1,919	2,470	405	183
RYCOM	250	300	250	180
FEC	13,479	12,270	19,890	11,521

The percent of normal bed capacity and operating beds occupied as of 29 December 1950 was as follows:

	Percent Normal Bed Capacity Occupied	Percent of Operating Beds Occupied
JAPAN	114	114
KOREA	54	13
MARBO	39	39
PHILCOM (AF)	9.9	45
RYCOM	72	72
FEC	85	58

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Patients in Evac Hosp line up for noonday meal



Food is served in a fox-hole north of Seoul



Combat soldiers eating field rations in rain



Medical corpsman feeds injured soldier at Coll Sta, Korea



Wounded Corporal is assisted with meal at Mob Surg Hosp



Native food bearers carry rations to ROK troops, Andong, Korea

RESTRICTED



The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Major Vincent I. Hack, Editor

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